



## ***HEALTH HISTORY FORM***

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Referred By \_\_\_\_\_

Occupation \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone number \_\_\_\_\_ (check one) cell \_\_\_ home \_\_\_ work \_\_\_

Emergency Contact \_\_\_\_\_

Are you presently being treated for any health condition? Yes \_\_\_\_\_ No \_\_\_\_\_

Please explain if yes \_\_\_\_\_

Are you under a lot of stress? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you exercise regularly? Yes \_\_\_\_\_ No \_\_\_\_\_

What kind of exercise, if yes? \_\_\_\_\_

How would you describe your diet? \_\_\_\_\_

Do you smoke? Yes \_\_\_\_\_ No \_\_\_\_\_ Drink alcohol? Yes \_\_\_\_\_ No \_\_\_\_\_

Please list your medications, including supplements and multi-vitamins \_\_\_\_\_

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Have you received a professional massage before? Yes \_\_\_\_\_ No \_\_\_\_\_

Please indicate body parts that you give the permission to massage. Head \_\_\_\_\_ Neck \_\_\_\_\_ Face  
\_\_\_\_\_ Chest (pectoral muscles) \_\_\_\_\_ Abdomen \_\_\_\_\_ Arms \_\_\_\_\_  
Back \_\_\_\_\_ Legs \_\_\_\_\_ Feet \_\_\_\_\_ Buttocks \_\_\_\_\_

Have you had any alcohol and/or recreational drugs in the past 24 hours?  
Yes \_\_\_\_\_ No \_\_\_\_\_

Have you had any surgeries in the past year? \_\_\_\_\_ Explain \_\_\_\_\_

Have you had any accidents in the past year? \_\_\_\_\_ Explain \_\_\_\_\_

Do you currently have any concerns in the following areas or had them in the past? Please check and explain below.

**Musculo-Skeletal System**

Osteoporosis \_\_\_\_\_  
Broken/Fractured Bones \_\_\_\_\_  
Arthritis \_\_\_\_\_  
Sprains/Strains \_\_\_\_\_  
Back Pain \_\_\_\_\_  
Head injuries \_\_\_\_\_  
Spasms/Cramps \_\_\_\_\_  
TMJ Disorder \_\_\_\_\_  
Other \_\_\_\_\_

**Circulatory/Respiratory System**

Heart Condition \_\_\_\_\_  
Varicose Veins \_\_\_\_\_  
High/Low Blood Pressure \_\_\_\_\_  
Blood Clots \_\_\_\_\_  
Breathing Difficulty \_\_\_\_\_  
Asthma \_\_\_\_\_  
Sinus Problems \_\_\_\_\_  
Other \_\_\_\_\_

**Skin**

Allergies \_\_\_\_\_  
Psoriasis \_\_\_\_\_  
Rashes \_\_\_\_\_  
Warts \_\_\_\_\_  
Fungus \_\_\_\_\_  
Other \_\_\_\_\_

**Digestive System**

Abdominal Pain \_\_\_\_\_  
Nausea \_\_\_\_\_  
Bloating \_\_\_\_\_  
Irritable Bowel Syndrome \_\_\_\_\_  
Other \_\_\_\_\_

**Women Only – Reproductive System**

Are you pregnant? \_\_\_\_\_  
What stage? \_\_\_\_\_  
PMS \_\_\_\_\_  
Other \_\_\_\_\_

**Nervous System**

Headaches \_\_\_\_\_  
Numbness/Tingling \_\_\_\_\_  
Fatigue \_\_\_\_\_  
Sleeping disorders \_\_\_\_\_  
Depression \_\_\_\_\_  
Other \_\_\_\_\_

**Miscellaneous**

Teeth Clenching/Grinding \_\_\_\_\_  
Fibromyalgia \_\_\_\_\_  
Diabetes \_\_\_\_\_  
Cancer/Tumors \_\_\_\_\_  
Other \_\_\_\_\_

I have stated all medical conditions I am aware of. It is my choice to receive massage therapy. I understand that massage therapists do not diagnose illness, disease or disorder, nor they prescribe medical treatment. I further understand that any sexual innuendo, propositioning or touch will result in the immediate termination of the session. I will still be responsible for the full payment.

Signature \_\_\_\_\_ Today's Date \_\_\_\_\_